Child Medical Statement

Childs' Name ——————————————————— Date of Birth_____

Height ————Weight ————

Limitations or health condition (including allergies, medications, dietary restrictions) _____

Immunizations: Please check one

Complete for age Yes_____ No ____

In Process Yes _____ No ____

Exempt from Immunizations: Please check one

Religious conviction Yes____ No _____

Health concern Yes ____ No _____

Other:_____

This child has been examined and is in suitable condition to participate in group care

_____

Signature of examining (check one)

Physician _____ Physician's Assistant _____ Advanced Practice Nurse _____

Address _____

Phone _____ Date of exam_____

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program				Reason not completed (Check which applies)	
Assessments/ Screenings	Completed **Please circle one**		Date Completed	Examples: religious conviction, insurance coverage, other	Health professional decision
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			